



Is it Just Simple Dermatitis or Eczema?

Öner Özdemir

A 21-month-old boy developed pruritic, erythematous, and scaly rashes on his face, neck, and dorsum of the hand since the day following fever that occurred 2 months before presentation. First, he was thought to have viral exanthem with superimposed bacterial infection by his pediatrician. Accordingly, antibiotics and antipyretics were prescribed. One week later when the rashes did not improve but progressed, he was taken to a dermatologist and an ophthalmologist due to skin lesions around his eyes. They considered that the patient had dermatitis due to his sensitive skin and suggested him to use a cream/pomade including antibiotics and corticosteroids. After 10 days of using these medications, he did not experience any benefit. Then, the patient was presented to another pediatrician who considered the patient to have superficial fungal skin infection. At this instance, he was administered an antihistamine syrup and cream including antifungal, anti-inflammatory, and antibacterial ingredients. Five days later, the family was referred to a pediatric allergist who diagnosed him with probable atopic dermatitis (eczema) and convinced the family to admit the patient for treatment. A couple of days after treatment with systemic corticosteroids, antihistamines, and antibiotics, the lesions showed no improvement. Therefore, they consulted another dermatologist, and skin punch biopsy was decided to perform. What is the diagnosis of the protracted lesions on his skin shown in Figure 1?

Skin punch biopsy confirmed childhood (pediatric) psoriasis. Diagnosis of psoriasis is more challenging during childhood due to its unusual clinical appearances. Psoriasis is known to be a frequent protracted inflammatory skin disorder affecting 0.5%–2% of children and 2%–4% of the general population, although infants are rarely affected (1–4). Although the extensors of the limbs, scalp, and flexures are the key body areas affected in childhood psoriasis, the face, periauricular area, and eyelids are also usually involved such as in the present patient. The clinical presentation of pediatric psoriasis appears similar to that of adult psoriasis, but some clinical characteristics are remarkable. For instance, the type of plaque psoriasis is more common and lesions are often smaller, less scaly (scales are finer and softer), and sometimes less distinct compared with those in adults (1). Its differential diagnoses include atopic dermatitis (eczema), acrodermatitis enteropathica, Candidiasis, pityriasis rosea, pityriasis rubra pilaris, guttate lichen planus, and deficiency of the interleukin-1/36 receptor antagonist to exclude different morphological patterns in psoriatic disease (2–5). However, childhood psoriasis is mostly confused with atopic dermatitis (eczema), nummular dermatitis (nummular eczema), pityriasis rosea, or superficial fungal skin infections. Psoriatic lesions of the hands, feet, or scalp and annular psoriatic lesions on the trunk need to be differentiated from tinea. Plaque formation on the scalp is common and may be tough to distinguish from that observed in seborrheic dermatitis. Psoriasis in the napkin area is often confused with irritant or seborrheic dermatitis or Candidiasis (4, 5).

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Figure 1. Pruritic, erythematous and scaly rash on the neck, hand and face of 21 -month-old boy

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